rapidity of travel today, especially by air, with its associated possibilities in the spread of diseases, epidemiology must more than ever take its place as a protective science.

San Francisco Department of Public Health.

(To be continued)

CLINICAL NOTES AND CASE REPORTS

INSTRUMENTAL PERFORATION OF THE RECTUM

By KENNETH E. SMILEY, M. D.
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PERFORATION of the rectum into the peritoneal cavity with the proctoscope, or with instruments passed into the rectum for treatment, has been reported infrequently, yet the danger must be recognized and constantly borne in mind. Without early recognition of the condition and prompt surgical repair of the perforation, fatal outcome is inevitable.

Injury to the rectum by falling on to sharp objects, by gunshot wounds, and by the sudden dilatation caused by compressed air is not uncommon. Spontaneous perforation or rupture caused by enemata under pressure may occur in ulcerative conditions, and indeed may occur spontaneously. Barron, in a very comprehensive paper on simple nonspecific ulcer of the colon, collected fifty cases from the literature and added three of his own. Spontaneous perforation into the peritoneal cavity occurred in the majority of these cases.

Brumbaugh reported a perforation following an attempt at sigmoidoscopy by an inexperienced individual. Goldman reports three such cases, the first in an individual with a normal bowel, the second in an individual who had had a severe diarrhea for several days, and the third occurring in a case of chronic ulcerative colitis.

REPORT OF CASES

Two cases of instrumental perforation are reported in this communication—one with a rectal stricture, and the other with probably a normal bowel.

CASE 1.—The first case is that of a male, age 52, who had neurosyphilis for which he had received intensive treatment for a number of years. He also had a stricture of the rectum of long standing. Because of this stricture, his physician had given him, two days previously, a Jelk's irrigating tube to use at home. The second time he used this, he experienced considerable difficulty passing the tube beyond the stricture, and experienced severe pain in the rectum. However, he irrigated the bowel and very shortly afterward began to have severe upper abdominal pain. He was seen by a physician, who made a provisional diagnosis of a tabetic crisis and gave morphin twice without relief, and then sent the patient to the hospital, where I saw him, it then being approximately twelve hours after the use of the irrigating tube. He appeared to be in great distress and exhibited all the classical signs and symptoms of shock. The abdomen was board-like and slightly distended, and a shifting dullness was present. On rectal examination, a stricture which admitted only the tip of the finger was found. Temperature was 97 degrees; pulse, 100; white blood count 4,000 with 67 per cent polymorphonuclears. A diagnosis of rupture of the rectum was made and, in spite of the very poor prognosis, operation was advised as offering the only hope of recovery. On opening the abdomen a large amount of seropurulent material was aspirated, and a perforation just above the peritoneal reflexion was found. The perforation was repaired with considerable difficulty owing to the extremely friable bowel wall, and the abdomen closed with drainage. The condition of the patient gradually became worse, and he died ten hours later.

* * *

CASE 2.—The second case I am allowed to report through the courtesy of a colleague. The patient was a woman, fifty-four years of age, who complained of vague upper abdominal distress. In the course of a complete study, a sigmoidoscopy was attempted by an inexperienced individual. It was stated that the patient complained of very severe pain at the time of the examination, and that the examiner believed he saw a small ulcer and a bleeding point on the bowel wall. The patient was fairly comfortable until two hours later, when she began to have severe, generalized abdominal pain, which gradually increased in severity and was accompanied by a board-like rigidity of the abdomen. A diagnosis of rupture of the rectum was made, but operation was refused. At autopsy a perforation of the rectum was found without indication of any previous pathology in the bowel wall.

Such accidents probably occur much more frequently than the reported cases would indicate, and yet in this day of the indiscriminate use of colonic irrigations by incompetent individuals, gyser-like enemata, and all types of rectal instrumentation, it is small wonder that we do not see perforations with much greater frequency.

With a history of some type of instrumentation or treatment, and with the usual signs and symptoms of perforation of the bowel, diagnosis should not be difficult. Early operation offers the only possible chance of recovery.

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AN UNUSUAL CONGENITAL UROGENITAL ANOMALY

REPORT OF CASE

By D E. F. EASTON, M. D.
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ON August 3, 1931, Mrs. L. G. came under observation for a pain in the left upper abdomen, which had been there since a severe fall in June. As a question of public liability was concerned, a complete physical examination was

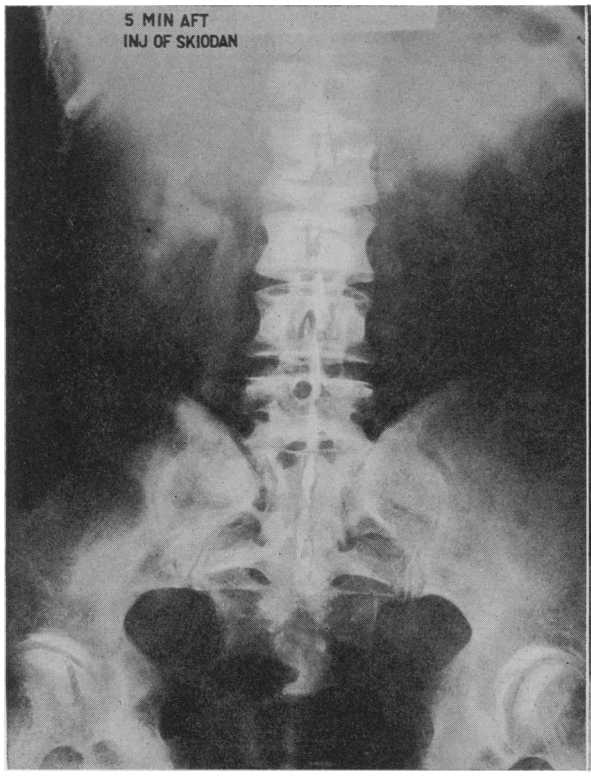

Fig. 1.—Taken five minutes after injection of skiodan. Right kidney and ureter visualized. Left kidney not seen. Spina bifida.

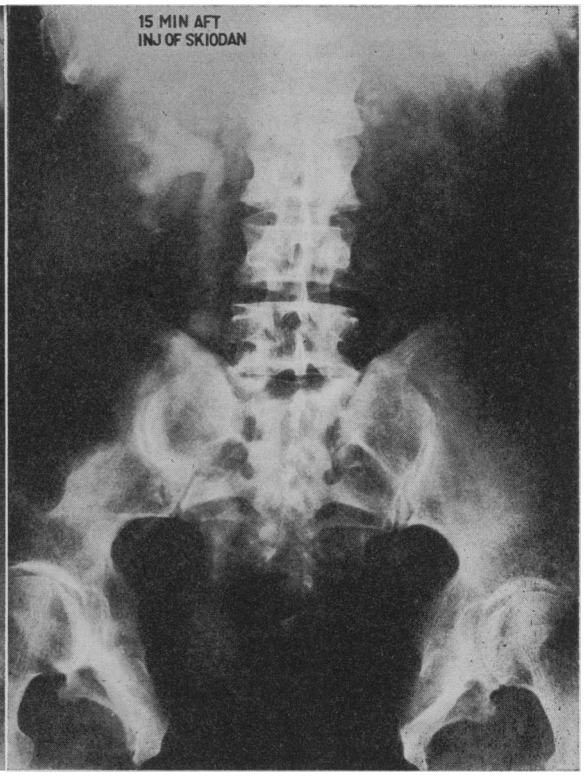

Fig. 2.—Taken fifteen minutes after injection of skiodan. Right kidney and dilated ureter more distinct. Sac-like dilatation visible. Shows congenital absence of pubic symphysis.

made. In the course of the examination the congenital urogenital anomaly about to be described was disclosed. For the sake of brevity details regarding all parts of the body except the abdomen and urogenital systems have been omitted, as they have no bearing upon the condition under consideration.

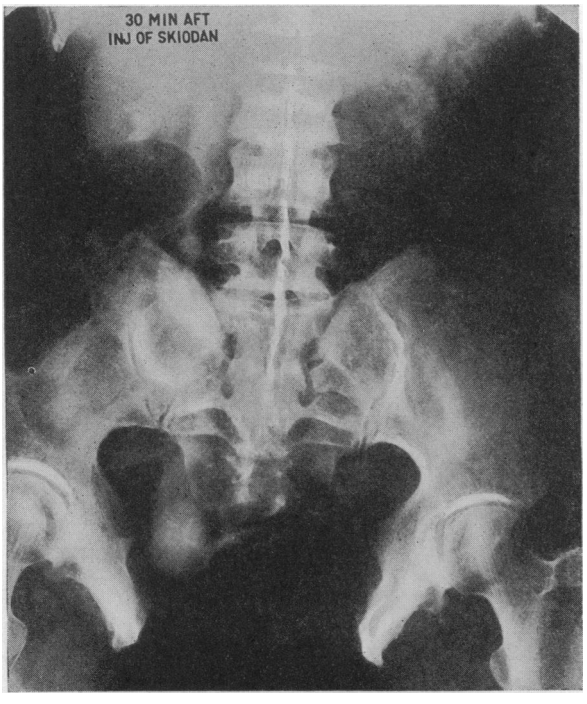

Fig. 3.—Taken thirty minutes after injection of skiodan. Shows sac-like dilatation of ureter more distinctly. Diverticulum at upper portion of the sac. Absence of bladder. No kidney or ureter visible on the left side.

REPORT OF CASE

Patient was slender and well nourished; age, 60 years; height, 5 feet 6 inches; weight, 128 pounds.

Examination of the Abdomen.—Abdomen was slightly distended and tympanitic. A rounded mass about the size of a small orange was felt in the left upper abdomen over the site of pain, the nature of which was at the time undetermined. There was no umbilicus. There was an apparent exstrophy of the bladder and a circular mass three inches in diameter over the pubic region, raised about an inch above the surrounding skin. Above this mass was a small area of ichthyosis and a very few pubic hairs. Urine seeped involuntarily through a tiny opening in the lower median portion of the mass. This mass was covered with mucous membrane. There was no clitoris, the mucous membrane covering the mass being continuous down into the vagina, which in the recumbent position was directed inward, downward, and backward. The labia minora were rudimentary, being one and one-half inches long; hard and rounded. The labia majora were also rudimentary and widely separated. No abnormality of the uterus, tubes, or ovaries. There was no urethra in the usual position.

Consultation with Dr. George L. Eaton was had on the same day, and a cystoscopic examination decided upon. She was admitted to the St. Francis Hospital the next day. Under ethylene gas anesthesia the tiny opening in the mass was gently dilated and a cystoscope inserted. Catheterization of the ureters was not accomplished. On August 5, 20 cubic centimeters of a solution of skiodan was injected intravenously, and x-ray pictures taken five, fifteen, and thirty minutes afterward.

Skiodan Examination of Kidneys and Ureters.—Fig. 1 shows film, taken five minutes after injection, and reveals complete visualization of the pelvis and calices

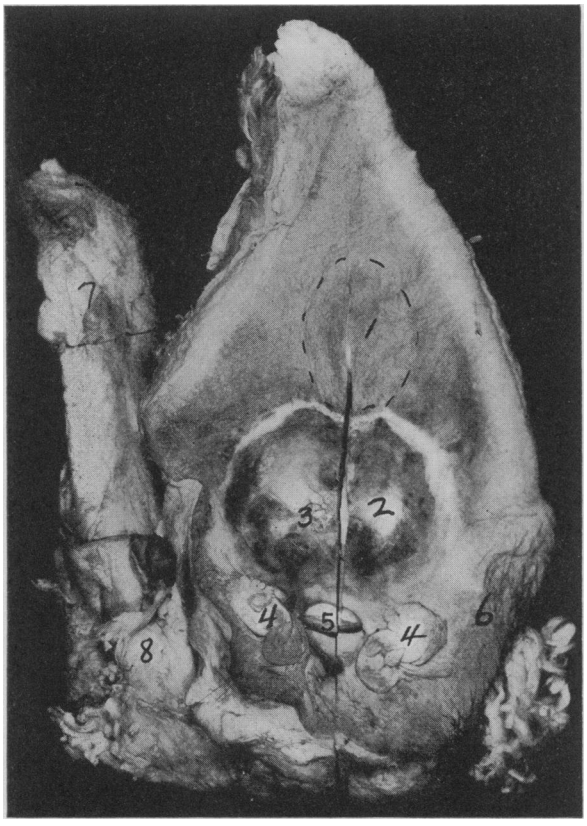

Fig. 4.—The numbers indicate the following: 1. Ventral hernia outlined. 2. Mass over the pubic region. 3. Opening through which urine seeped. 4. Labia minora. 5. Vagina. 6. Labia majora. 7. Distended ureter. 8. Sac-like dilatation of ureter.

of right kidney; also the right ureter. These all show a generalized dilatation, dilatation being most marked throughout the upper portion of the ureter. In the right kidney are two small densities which are apparently calculi. No visualization noted throughout the left kidney and ureter. There are several areas in the region of the lower pole which are suggestive of calculi.

Fig. 2 shows film, taken fifteen minutes after injection, and shows accentuation throughout the right, the ureter being a centimeter in diameter. The bladder consists of a small pouch which lies on the right side of the pelvis. No visualization of the left.

Fig. 3 shows film, taken thirty minutes after injection, and shows a slight decrease in visualization throughout the right with no visualization on the left. Sac-like bladder is somewhat accentuated.

The pelvis reveals a congenital anomaly in which there is an entire absence of symphysis.

She became progressively weaker, suffering intensely from nausea and taking very little nourishment. On August 23 she was paralyzed on the left side (arm and leg) and died at 7:10 a. m.

Autopsy.—Autopsy was done by Dr. A. M. Moody, the findings of which were as follows: A marked edema of the brain was noted. Healed tuberculosis at apices of both lungs and several scars. Pleural adhesions on both sides to the chest wall. Right kidney very large and congested. No stones were present, but a quantity of pus and gravel. Pronounced hydronephrosis and pyonephrosis; widely dilated ureter, which ended as a rounded, elongated sac. There was no bladder, the sac-like dilatation of the ureter taking its place, and lying entirely on the right side of the pelvis. On the left side was a very small kidney, about the size of an English walnut, imbedded in a large amount of fat and fibrous tissue which held it firmly in place and made it very difficult to remove. (This was the mass felt on the left side.) There was no ureter on the left side. The left kidney probably never functioned. There was a chronic, retrocecal appendix with many dense adhesions. Uterus, tubes, and ovaries were normal. There was a small ventral hernia just above the mass over the pubic region, in the sac of which the omentum was firmly adherent. In the wall of the hernia, under the skin; there was some scar tissue, although none showed on the surface. This must have been the place where the umbilical cord was attached. There was a total absence of the pubic symphysis, and of the ascending and descending rami of the pubis on both sides.

The cause of death was exstrophy of the bladder, causing ascending ureteritis and pyelonephritis of right kidney.

It is remarkable that she had attained the age of sixty years with such an ascending infection, and also that she could walk with no apparent change in gait, although the pelvic girdle was so incomplete.

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SACCULAR DILATATION OF SAPHENOUS VEIN

SIMULATING TUMOR OF THE GROIN

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THE following report may be of interest for several reasons—first, because of its rare occurrence. Not more than ten or eleven instances are found in the literature since 1835, when Boinet [1] reported his first case in the medical journal of Paris. It is of interest, also, because of the fact that with every patient so reported the surgeon has been caught off guard and led to make an incorrect preoperative diagnosis.[2 to 8]

The present case is distinctive because of the large size of the mass, and in that it contained a solid clot, presenting a hard lump in the groin instead of the usual soft swelling, which, in most cases, has been mistaken for femoral hernia.

REPORT OF CASE

S. M. Age, 54. Entered hospital December 29, because of a hard swelling in left groin. Family history negative. Personal history negative, except for injury ten years ago.

Patient stated condition began in 1930, when she noticed a soft, compressible lump in the left groin.

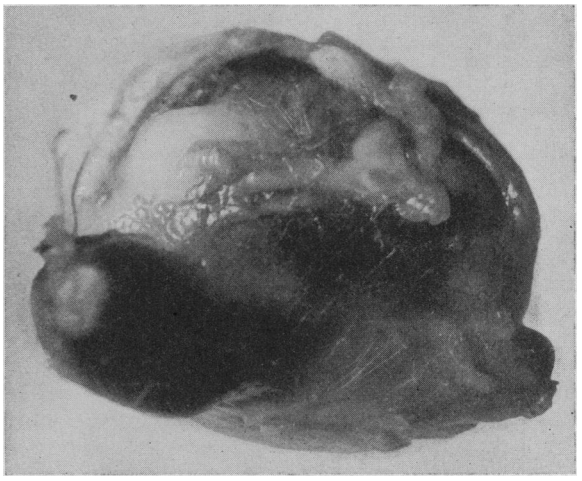

Fig. 1.—Sac unopened.